Kenneth Langlieb. Ph.D., Psychologist lic # 35SI00307300
60 West Ridgewood Avenue, Ridgewood New Jersey 07450
973-208-0085

December 26th, 2008

FILED WITH THE BOARD OF
PSYCHOLOGICAL EXAMINERS
ON December 29 2008

J. Michael Walker, Executive Director
New Jersey State Board of Psychology Examiners
124 Halsey Street, Sixth Floor
P.O. Box 45017
Newark, New Jersey 07101

Dear Mr Walker:

Please find enclosed my answer to the allegation. Two copies are enclosed and one sent to Siobhan B. Krier, Deputy Attorney General.

Sincerely,

Kenneth Langlieb, Ph.D.

K Langlieb Ph.D.

Cc: Siobhan B. Krier
Deputy attorney General
Division of Law
P.O. Box 45029
124 Halsey Street, 5th Floor
Newark, New Jersey 07101

General Allegations

1. Agree. Basic information on legal statutes
2. Agree. Definition of "Board"
3. Agree Dr Langlieb has NJ Psychology License
4. Agree. Dr Langlieb has MA, PhD, Post-Doctoral studies at Rutgers.
Additionally, an internship at the University of Houston Counseling Center, a year of supervision at Indiana St University Counseling Center. Other work experience as detailed in Vita.
5. Agree. Dr Langlieb's office has been located at 60 Ridgewood Avenue since October 1994.
6. Agree on B.A.'s demographics

COUNT I

7. N/A Legal definition.
8. Agree 9 Sessions, then approx 10 months later 21 more sessions.
9. Deviated from accepted practice:

a) Lacked training experience and education in multiple suicide.

Disagree. Dr Langlieb has been trained on the issues of suicide, suicide management and has experience treating clients who are depressed and have suicidal thoughts and tendencies. Below is an overview of training and experiences:

Training for Hotline at Farleigh Dickinson University
Orientation during Internship at University of Houston
APA Workshop on Cognitive approach to Depression by Steven Hollan, Ph.D.
Trained as part of position at St Claire's Hospital Consultation and Education Department. Consultant and Trainer to teach public school teachers how to recognize signs of suicide and how to respond. As a result of said training, presented several workshops on recognition and prevention of suicide.
Previous experience with several suicidal clients with both no attempts and at least 1 previous attempt at suicide.
Treatment of parents after a child completed suicide.
Treatment of family members who experienced loss thru suicide
Experience having a several low risk, medium risk, and medium high risk clients.
Experience with a few high risk clients who either voluntarily admitted self to hospital for preventative care on my recommendation or were involuntary committed.
Experience with clients who were medium to high risk, but were able to reduce the risk to low risk with appropriate interventions. (i.e.: removing the ability to commit suicide, having family and/or support members take patient into immediate care and supervision while removing the *suicidal threat/method).*
Experience with Hospital emergency Room Psychiatric Treatments, St Mary's Hospital.
Also addressed the needs of dying patients in their last hours of life.

Hospital experience with many inpatients after suicide attempts: Children's Hospital of NJ Experience in several mental health centers dealing with suicidal clients: Wayne CMHC, Clifton CMHC, Rutgers Graduate Psychology Clinic and Indiana State University Counseling Center. Personal experience with family member with history of suicide attempts. This has particularly sensitized Dr Langlieb to the issues of suicide.

9 b) Dr Langlieb failed to consult B.A.'s other doctors when B.A. Initially presented.

Disagree. B.A. had indicated on the intake sheet that she was taking Mobic, Ambien and Zoloft. Her previous therapist was Marie Pinto, her family physician was Dr Ho. The client knew of Dr Langlieb thru Dr Langlieb's colleague Dr L Lei, MD. The client was participating in a treatment with Dr L. Lei. Dr Langlieb asked the client's permission to consult with Dr Lei. The client gave Dr Langlieb permission and Dr Langlieb consulted with Dr Lei. There was no Psychiatrist of record reported by the client or detailed on the intake sheet.

ii. Agree. B.A. attempted suicide 5/2005.

B.A. had expressed that she was banging her head against a wall and a neighbor reacted by calling 911 and the client was taken to the hospital. The client did not present herself as having wanted to die. A verbal contract was successfully established with B.A. to contact Dr Langlieb if she had any serious thoughts of acting out a suicide again. B.A. agreed. Subsequent, B.A. never called Dr Langlieb to indicate that she had suicidal thoughts or intentions. In therapy, B.A. never indicated that she had any thoughts of suicide or intentions. There were no more attempts at suicide while under Dr Langlieb's care.

iii. Agree. B.A. resumed treatment in April 2006 following a long break and she had suffered from deep depression.

B.A. had not participated in therapy for a period of 10 months. She had left therapy to take a summer vacation and did not return to therapy for 10 months. During her absence from therapy, she reported experiencing a deep depression. She reported that prior to returning to therapy, she was in a much better place: had come out of the depression and had successfully participated in a 12 week course on grief. That during the grief work she had experienced deep feelings that were brought out by the grief course. B.A. stated she had used techniques to express her unexpressed feelings, was able to clear the air and get out of the depression.

After this initial session, B.A. went on a long vacation / tour of Paris, London and Rome. She was very excited and positive about "seeing" the touch exhibits of art. Additionally, she reported having a positive connection with Rev. James Warnke, MSW. The client did not return to therapy for another 6 weeks. When she returned, she reported having had a great trip and was feeling very positive.

9c) Disagree. Dr Langlieb failed to detail in the records how or if he explored reasons for 5/2005 depression

B.A.'s reasons for feeling depressed related to a multitude of losses, historical and recent. Historical loss of ambulation, sight, father, mother, loss of love, loss of a husband, inability to find unconditional love or reciprocal love, loss of 27 year career as a fine jeweler, social status as a business owner, finances, attractiveness, purpose, social contacts, loss of rewarding contacts with her prestigious clients and loss of driving ability. The recent and the latest, loss of her personal assistant and the conflicts she had with her triggered what the client referred to as "another loss in a long line of losses."

Therapy focused on regaining or replacing those import losses that were possible to replace. The client had in fact made some initial steps towards reestablishing herself in a new career, replacing her driver, making new social contacts thru the church, increased her ability to get around, ability to feel beautiful and attractive, to have a relationship with an appropriate male, was able to re-activate her NYC handicapped permit, was able to renew her drivers license.

Although not specifically detailed in the progress notes on that day, the indication of "an accumulation of losses" LOSS was noted and reference to the previous losses was already recorded in previous notes.

d) Disagree. Dr Langlieb lacked training in managing B.A's infatuation and/or transference. Dr Langlieb was aware of infatuation issue but engaged in conduct that exacerbated the situation including taking her out for ice cream, giving her a book, allowing her to touch my face, attending a meditation retreat and disclosing personal information about myself.

I. Disagree. How infatuation was managed. When arose. B.A. stated therapist did nothing to elicit the infatuation. Enumerate boundary setting steps.

At the 8th session on June 2nd, the client had indicated that she was planning to terminate therapy, go on a 2 month vacation to Napa Valley, San Diego and other spots in that area. She indicated that she had friends out there she wanted to visit, and site to see. Going out for ice cream was an aspect of putting closure on the therapy and winding it down.

On June 8th, 2006, the 9th therapy session, the client was expressing her feelings about the past suicide attempt. I had restated the Boundaries of the therapeutic relationship. The client had shown that she understood and accepted the Boundaries. She stated that she had changed her mind about terminating therapy. She stated that she was benefitting from therapy and that the she was getting good therapy. The client requested to "see" what the therapist looked like by touching his face. As a clear boundary had been established and accepted by the client, tone and reaction of the client was like that of a person seeing for the first time, someone that they had known for a while. A mix of curiosity and clarity of knowing something she previously was unable to see. The result was that the client was more at ease and sure of herself. There was an absence of sexuality. More so, it took the clients imagination out of the realm of fantasy and placed in into reality.

On November 14th, 2006 the client had spent time crying and lying on the couch. As a technique to improve her outlook on life, she was introduced to a book of affirmations entitled "Is it Time to make a change? Positive Thoughts for when Life Presents you with a New Direction." The positive affirmations in the book matched and countered many of the negative thinking patterns the client was holding on to. The goal was for the client to review the positive statements and select the one's she felt were most encouraging and inspiring. The book was not a gift but a tool loaned to the client.

On April 25,26,27,28 2006 the therapist attended a meditation retreat. The therapist had a small role in co-leading some of the meditations. At this point, the client had been absent from therapy for a period of 10 months. At the time of registering for the retreat, there was no indication that the client would be attending either the retreat or therapy. Just 7 days prior to the retreat, the client attended one therapy session. When it was learned that the client was thinking of attending the retreat, it was discussed if either one should drop out of the retreat. In carefully exploring the options, it was decided that since there would be no significant interactions at a silent meditation retreat, the client would be comfortable with the therapist there. Given several options, the client elected to maintain the confidentiality of the therapeutic relationship, not to totally ignore, nor engage is social conversations during the retreat. The therapist would occasionally greet and say hello to the client, but otherwise they would maintain separate social circles. There were only two group interactive events at the retreat and the therapist elected not to participate in either one.

Some selected personal information that was disclosed to the client was intended to inspire the client and encourage her to overcome her challenging obstacles. The therapist shared his personal experience with being visually impaired and how he was able to overcome great obstacles to establish a professional career. The therapist also disclosed to the meditation group, including the client, his success at swimming across the Hudson River as a fund raiser for Multiple Sclerosis. A third piece of personal information came to the client's attention several months after therapy was terminated regarding the loss of a family relative. This information did not come from the therapist, but was part of a mass emailing to the meditation group that was made without his awareness.

ii. Disagree. Dr Langlieb failed to consult with a colleague, treating psychiatrist or seek supervision or guidance re: persistent transference issues.

Dr Langlieb consulted with colleagues and supervisor about addressing the infatuation. The advice was consistently to set limits, set boundaries, clearly state that the boundaries could not be crossed, let the client clearly know that there could not and would not be any personal relationship at any point. Dr Langlieb followed that advice and repeated these statements many times to B.A. at every point in which she had made a reference regarding Dr Langlieb.

Dr Langlieb's initial remarks and boundary setting were based on previous training. When B.A.s remarks resurfaced later on again in therapy, Dr Langlieb discussed this with colleagues who

took a more psycho-dynamic / analytic approach for suggestions as well as supervisor. The advice was similar to previous training approaches.

iii. Dr Langlieb failed to seek additional training in transference issues to understand his possible role in fostering same or to avail himself to more effective ways of addressing the occurrence, thought he reported numerous female patients have been infatuated with him and his usually approach was ineffective .

Re: Dr Langlieb had numerous female patients that had been infatuated.

There were five previous clients in memory over the past 25 years, four females and one gay male, who had expressed an interest in either a friendship or personal relation. Three accepted the boundary on the first correction, and a fourth accepted the boundary limit after a second reminder.

One male patient during internship, coming out as gay accepted the boundary right away. To assist the client in meeting appropriate partners and learning how to socialize with the gay community, a gay support group at the center was formed which allowed other isolated gay clients who were in individual therapy to seek and find mutual support in an open and excepting environment. That client successfully went on to find a dating partner.

One female client made seductive remarks at two sessions. After setting limits at both sessions, she stopped the remarks and focused on the speech anxiety she was attempting to derail.

One elderly female client wanted to be friends and was told that was not possible. She accepted the limit right away. The focus was redirected back into the social phobia issues she was diverting from.

Another middle aged female client presented with flirtatious remarks from time to time. Boundaries were set and the client limited her behaviors to the occasional remark.

One stronger case of attraction, a victim of incest, who came in for treatment of panic disorder, was successfully referred out to work thru the issues w/ another therapist

In the case of B.A., she initially accepted the boundaries on the second session following her disclosure of feelings of infatuation. During her 6th sessions of 5/19/2005, which was after her suicide attempt, she made some unsolicited flattering remarks to Dr Langlieb. Dr Langlieb clearly and explicitly set the boundaries, advised the client that there could not be any personal relationship with her therapist, and would not be. This was stated in three different ways to B.A. At the following session on 5/24/2005, the client made no inappropriate comments and focused on her therapy issues of redefining her life.

At the next session on 6/2/2005 the B.A. announced that she was taking the summer off and traveling thru Napa Valley, San Diego and other tourist spots in

California for a vacation. She also announced for the first time that she felt infatuated with Dr Langlieb. As a means of gaining closure with B.A. and taking her out of the dynamics of the therapy environment, Dr Langlieb went out for ice cream at a store 1 block from the office. The advantage of being in a public place reduced the clients focus on her infatuation and helped bring her therapy to a close. Although her behavior in public was appropriate, as soon as we returned to the therapy office to end the session, B.A. made a playful and joking comment: "I know why you took me for ice cream; you wanted to see me lick it." This sounded like a sexual reference as well as expressing that while Dr Langlieb could see what other people were doing, she was feeling at a disadvantage and loss for not being able to visually experience what others were able to see. Comments like this are often taken as an indirect request to be the blind person's "eyes" and to tell them what is happening around them. As this was a therapeutic outing my focus was on our verbal topics and not on the surrounds. Had this been a recreational trip with a blind person, as I have done with "A.B.L.E' I would have been the persons eyes. Perhaps in retrospect B.A. would have benefited from some form of information about what was happening around her.

In spite of B.A. having stated that she was leaving for the summer, on 6/8/05 she returned for one more session. Dr Langlieb reinstated the firm boundaries. At this second session after the client had disclosed her feelings of infatuation, she verbally expressed that she accepted the boundaries, expressed that she felt she was getting good therapy and wanted to continue. From that point on, the focus of the therapy was on her feelings of depression.

B.A. accepted the boundary on the eighth session after her initial remarks of infatuation

Dr Langlieb is aware that client's feel safe in the therapy room to express sexual feelings as they know they will not be acted on. Clients know that they will not be rejected as patients and Dr Langlieb see's his role as preparing clients to take interpersonal risks and face potential social rejection in the real world, and to look at their fears and insecurities. In therapy, the fears are explored and worked thru to seek out dating emotionally available persons. B.A. was making those steps to meet people in appropriate social arenas.

e) Disagree. Dr Langlieb abandoned and neglected B.A. on two occasions for one month without coverage.

B.A. had demonstrated her ability to tolerate separations between two and four weeks on several occasions. Additionally, Dr Langlieb was available by phone during all separations should B.A. have the need for and want to talk.

There were several periods when B.A. scheduled her sessions two, three or four weeks apart. B.A. also had use of her previous therapist Ms Pinto, Dr Lei a medical who she frequently confided in, Dr Ho as well as 911 for emergencies. B.A during the course of therapy did not indicate she was in need of weekly or even bi-weekly support during the 2 four week

separations. B.A. did not call during either of the 2 four week breaks not did she indicate that she was in any great distress as a result of the separation.

Although B.A. has an irrational fear of abandonment, there was no basis in reality that the therapist was abandoning the client. B.A. did express irrational concerns about loosing contact and fear of a future more permanent loss which were addressed during the session.

B.A. routinely made appointments two, three and four weeks apart. Once she did not attend therapy for six weeks. Some examples are as follows:

Five periods client elected not to have therapy for a two week period.
One period elected not to attend therapy for one month (1/23/07 thru 2/20/07)
One period client did not attend therapy for five weeks (4/13/05 thru 5/19/05)
One period client did not attend therapy for eight weeks (4/18-06 thru 6/17/06
One period client elected to not attend therapy for ten months. 6/8/05 thru 4/18/06

These periods are exclusive of therapists two four weeks periods.

Dr Langlieb called in for messages daily or every other day. There no messages from B.A. requesting help or support. There was no indication that B.A. had any difficulty in making a call for help or that she had any hesitations about asking for help. Although B.A. was down at the beginning of therapy 9 months earlier, there was no indication that she had any suicidal ideas, plan or intent during either of these two periods of separation.

B.A. had made friends thru the church, connection to James Warnke, an expert on therapy with blind clients, who spoke with her thru the holidays.

The July 2006 four week vacation followed a ten month break the client had elected to take. The three previous sessions were spread out over six week intervals. Although the client had reported being in a deep depression during the ten months she had elected to discontinue therapy, she had reported that prior to the four week vacation, the client had pulled out of the depression and had enjoy a tour of Europe visiting art galleries. Her issues were in establishing herself in a new career and exploring voice over's as an alternative new career.

f) Disagree. Dr Langlieb abandoned / neglected B.A. when Dr Langlieb terminated treatment shortly after returning from a long absence on 2/27/08, without helping B.A. w/ alternative assistance.

B.A. had self terminated therapy. B.A. was focusing on her poor self image and questioned her ability to be a desirable partner to a man. The therapist suggested the client consider speaking with a sex therapist or other type of therapist that would help her with her body dysmorphia. Dr Langlieb did not indicate that B.A. could not or should not continue therapy. Additionally B.A. had previously been referred to a Clinical Social Worker who is a top leading therapist in the field of loss issues of visually impaired persons. At one point B.A. had called Dr Langlieb and reported that she was feeling low. Dr Langlieb suggested she either come

into the office for a therapy session or if there was an immediate need, B.A. could have a phone session. B.A. declined to receive treatment either in the office or on the phone as offered.

B.A.'s approach to therapy had changed in that her motivation had become more of an opportunity to visit a friend than to focus and work on therapeutic issues. Dr Langlieb confronted B.A. asking her if she was in therapy to work on her issues or to visit a friend. She indicated she wanted a friendship. When B.A. was told there would not be a friendship outside of therapy, her response was "I want you any way I can have you." At this point Dr Langlieb was considering terminating the therapy. Therapy seemed to be reaching its natural conclusion. B.A. realized she could not foster a friendship with Dr Langlieb.

g) Disagree. Dr Langlieb failed to prepare and maintain B.A.'s client record for sessions held on March 11, 2005 and January 30, 2007.

Every session had progress notes. No sessions were without notes. On the two dates: March 11, 2006 and January 30, 2007 there were no sessions. March 11, 2007 was a Friday, when the office is closed. This was a clerical error. January 30, 2007 B.A. did not attend her scheduled appointment due to illness.

10) Disagree. Dr Langlieb's conduct constitutes gross and repeated acts of negligence in violation of ..... professional misconduct....failure to prepare and maintain records, failure to practice within area of competence, abandonment and neglect.

Most of the information contained in count one was either misrepresented, incorrect or distorted. Please consider to complete picture as reported above.

COUNT II

11. N/A

12. Disagree. Allegation: Inappropriate touching, sexual harassment and sexual contact as follows:

a) Disagree. Allegation: Dr Langlieb discussed his personal preference for sexual positions. This is false. Dr Langlieb did not make any such disclosure. The only disclosures were on the part of B.A. in the normal course of conducting the intake. B.A. has a normal desire to have an intimate relationship with a man. She does not have a satisfactory intimate relationship with her husband. In assessing the cause of the dissatisfaction, B.A. related what her ability level was as a person who was paralyzed from the waist down and what she was capable of experiencing within the context of an intimate relationship. Her responses were appropriate.

b) Disagree. Dr Langlieb made an inappropriate remark to B.A. regarding a six- inch frozen pop on a stick.

While out in public, B.A. requested to be informed what other customers were doing at the store, who they were with and if they were standing, sitting or walking. B.A. asked about what other stores were in the area near by. She was eating an ice cream cone. Once we returned to the office she made what sounded like a playful remark as follows: "Oh, now I know why you took me for ice cream, you wanted to see me lick it." Emphasizing the words "lick it."My sense this was partially playful, partially provocative and partially an expression of her limitations that she herself could not visually see others enjoying their ice cream and that she missed being able to see for herself the expressions of joy that they might have had eating such a treat. By her projecting and guessing what other's motivations were, she is also indirectly asking what others are thinking about her. My response was a reflective statement of her sentiment.

c) Disagree. Allegation: Dr Langlieb hugged B.A. at end of several sessions disclosing personal information.

Although B.A. had talked several times about the importance to her being hugged by her family members, during cold winter nights by her loving grandmother to keep her warm, and desire to be held and hugged by a loving man, Dr Langlieb did not hug B.A. At some point the B.A. was interested to know about Dr Langlieb's own experience with being visually impaired, which Dr Langlieb shared as a way of demonstrating his ability to empathize with her blindness. Dr Langlieb also disclosed the achievement of swimming across the Hudson River as a fund raiser for Multiple Sclerosis as a way of inspiring B.A. to set high goals and achieve them. The only other personal information that came to the attention of B.A. happened several months after therapy had already terminated. This was information about a family member that was circulated thru the email list of the meditation group and was not discussed between Dr Langlieb and B.A. during therapy or afterwards.

Dr Langlieb's normal use of brief hugging is limited to two basic situations. 1) Closure at termination of the last session when the client initiates the hug. 2) When a client reaches out during a shaky, crying episode expressing deeply shaking emotions. This usually last for a 10-15 seconds and confided to just that significant session. In the case of B.A., neither of these circumstances presented themselves.

d) Disagree. Allegation: Allowed B.A. to put her arm Dr Langlieb's waist and lean her head against Dr Langlieb's stomach. This never happened. The only time in memory is the possibility that when Dr Langlieb was asked to aid B.A. in moving from her wheel chair into a Black Mercedes SUV with a seat that appeared to be very much too high for her to lift herself into the set, and where she had a female driver, Dr Langlieb assisted B.A. in lifting her into the seat as per B.A. specific instructions on how she wanted to be

lifted. B.A. may have placed her arm around Dr Langlieb's should or possibly waist during the transition from the wheel chair to the SUV passenger seat.

e) Disagree in part. Allegation: Dr Langlieb sat on the floor to meditate in yoga position outstretched interlocking arms and head touching.

B.A. had been practicing meditation with Dr L Lei's meditation group. B.A. requested to sit on the floor and have a meditation session. Meditation is an effective technique for both grounding and calming. B.A. requested we sit knee to knee. As she was blind and unable to move her legs, this seemed like her way of normalizing the meditation experience and having a sense of where in space Dr Langlieb was. It gave her a sense of support and safety. Although this is not the normal practice for meditation with a sighted ambulatory client, it was however an adaptive approach for B.A. who is blind and non-ambulatory.

B.A. was positioning herself on the floor with her legs crossed in a meditative position. She attempted to hold her upper body upright. B.A. momentarily requested support for righting her upper body. Dr Langlieb offered his forearms as a sort of railing for her to independently right herself in an upright balanced meditative position. B.A. was instructed to focus her attention on her breath and at the point in the center of her forehead. B.A. had asked to lean her head against Dr Langlieb's forehead. Although this would ordinarily be an unusually request for a sighted person, there was some significant meaning for B.A. to have head to head contact while doing meditation. In an effort to extend method of meditation in the way B.A. had requested, Dr Langlieb allowed B.A. to position her forehead in line with Dr Langlieb's forehead. As a result, B.A. was able to feel a sense of acceptance that a blind person could meditate and receive support in the way she requested. B.A. was not able to offer any insight into how it actually helped her, so it was not continued.

f) Disagree. Allegation: Dr Langlieb hugged B.A., rocked her after every session after one point caress her clothed body and face w/ mutual thanking for affection given.

This never happened and nothing similar to this happened. Although B.A. spoke several times about the meaning to her of being held by a family member or loved one and wanting to be held by someone in her life, Dr Langlieb did not provide physical comfort to B.A. by hugging and/or rocking her.

At the end of some sessions B.A. did thank Dr Langlieb for being supportive. B.A. may have some form of affection for Dr Langlieb as her therapist. Dr Langlieb did care about B.A.'s well being, especially as she was a person of greater needs. Dr Langlieb did often express empathy and understanding for what B.A. was going thru. This was in the context of a therapeutic listening technique.

g) Disagree Allegation: Allowed B.A. to touch Dr Langlieb's hands asking B.A. how it made her feel.

At some point the client had asked to touch Dr Langlieb's hands as a way of "seeing" what Dr Langlieb looked like. Dr Langlieb asked what B.A. could tell from touching his hands. What her response might have been a few years ago is out of memory. This was a one time only exercise. Dr Langlieb had some ambivalence about this, but gave B.A. the benefit of a doubt on this one occasion.

h) Disagree. Allegation: Dr Langlieb pulled B.A. onto his lap, reached under her blouse, touched her stomach and back. Commented her skin was soft and felt her scars. Touched her vertebrae asking where her sensations ceased. Kissing each other on face and neck. B.A. touched Dr Langlieb's hair and Dr Langlieb said he liked it.

B.A. did not sit on Dr Langlieb's lap, either on her own volition or as a result of Dr Langlieb pulling her onto his lap. Dr Langlieb did not reach under her blouse, touch her stomach or back.

B.A. was self conscious of her scars and at one point did mention that she felt no one would want someone with her problems. Scars were mentioned as one of those problems.

B.A. had reported that she did not have sensations or had dull sensations in the lower portion of her body. She may have mentioned specific vertebrae, but that specific numbered vertebrae is not in memory.

Dr Langlieb did not kiss B.A. on the lips, face, neck or any other part of her anatomy. Neither did B.A. kiss Dr Langlieb. B.A. was looking for affection from a variety of men in her life, but did not talk about having an interest to kiss Dr Langlieb.

Dr Langlieb did not touch B.A.s stomach or back either over her blouse or under her blouse with the exception of the time Dr Langlieb assisted B.A. into her SUV as stated above.

There were sessions when B.A. made a point of dressing herself well with matching outfits. She was proud of her ability to match her clothes by color and by style. On several occasions she would talk about her outfits and how she matched them. On two or three occasions Dr Langlieb complimented her on her attire and inquired as to how she was able to match colors and styles without vision. One day B.A. came in with her hair done in a new style. She asked if Dr Langlieb liked her new hair style. She was again proud to look good. Dr Langlieb said it looked very nice.

The only similar situation Dr Langlieb can recall is her story about a male who had rubbed her back on the way to church. She reported how she enjoyed the physical contact.

i) Disagree. Allegation: Around 1/23/07 Dr Langlieb asked B.A. if she missed Dr Langlieb and asked what did she think would happen now. Lifted B.A. onto Dr Langlieb's lap and asked how she was feeling. She said she missed him and fantasized about him sexually. Then Dr Langlieb offered her to touch his chest. B.A. kissed Dr Langlieb's chest and sucked his right breast. Dr Langlieb stroked her clothed back arms and legs, kissed her face, reached down her sweater and touched her breasts commenting they would be nice to kiss and suck. B.A. kissed Dr Langlieb's face and lips for 10-15 min.

RESPONSE: On 1/23/07 it had been 4 weeks since the previous session. B.A. expressed concern about loosing contact with Dr Langlieb. This was assessed as separation anxiety. B.A. later expressed an interest to know what it would be like to physically touch a man's chest. She expressed how she imagined it would feel. B.A. did not make reference to Dr Langlieb in regard to her interest to be physically intimate with a man.

B.A. did not make a reference to a sexual fantasy about Dr Langlieb. Dr Langlieb did not lift B.A. onto his lap. Dr Langlieb did not offer to allow B.A. to touch his chest. B.A. did not kiss or suck Dr Langlieb's breast. Dr Langlieb did not stroke her clothed back, arms or legs. Dr Langlieb did not kiss B.A.s face, nor reach down her sweater and touch her breasts. Dr Langlieb did not make a comment about kissing or sucking on her breasts. Dr Langlieb and B.A. did not kiss for any length of time, either on the face or lips.

13. Disagree. Allegation: All above constitute professional misconduct sexual misconduct. Demands judgment for: suspension or revocation of license, penalties for each unlawful act, legal / administrative costs, other relief as deemed just and appropriate.

Although the referenced allegations represented in these complaints in their incomplete form appear to be professional misconduct, Dr Langlieb has provided the contextual frame of reference to more accurately orient the reader to the specifics of the points in the complaint. Some statements were half truths with some distortions overlaid, and others were fabrications from either a fantasized imagery or other source.

Respectfully submitted by

K Langlieb PhD

Kenneth Langlieb, Ph.D.